# APPEAL OF CAP-MR/DD DECISIONS

## 25. APPEAL OF CAP-MR/DD DECISIONS

This section describes CAP-MR/DD denials, reductions, and termination procedures and outlines the appeal process for CAP-MR/DD decisions. Also, this Section offers general information on the appeal of Medicaid eligibility and level of care decisions. DMH/DD/SAS offers technical assistance on processing appeals. Regardless of the type of appeal, the Case Manager offers support and assistance to the person/legally responsible person during the appeals process.

### 25.1 Appealing Medicaid Eligibility

DSS takes applications and determines eligibility for Medicaid. If a person/legally responsible person wants to appeal a decision about eligibility for Medicaid, the Case Manager refers the individual/legally responsible person to the local DSS. A person may appeal decisions regarding initial or continued Medicaid eligibility. He/she has 60 days from the date of the notice of denial or termination to request an appeal. An impartial official of the county DSS will hear the appeal, make a decision, and notify the individual of the decision, If the individual disagrees with the decision and wants another hearing, he/she must contact the DSS and request a State hearing. A hearing officer from the North Carolina Division of Social Services will conduct this hearing. A person who is not eligible for Medicaid is not eligible for CAP-MR/DD funding.

### 25.2 Appealing Disability Determination Decisions

If a person does not have Medicaid at the time he/she applies for CAP-MR/DD funding, the person may be referred by the local DSS to the State Office for Disability Determination for a decision regarding disability determination. Should this office decide that the person does not meet criteria, the person/legally responsible person will be notified and given the opportunity to appeal as well as timelines/process for the appeal. A person who does meet the criteria established for disability determination is not eligible for CAP-MR/DD Medicaid.

### 25.3 Appealing Level of Care Decisions—Initial Determination by Lead Agency

Upon referral to the Lead Agency, the person is recommended as potentially eligible for CAP-MR/DD funding or not potentially eligible. Should the person be determined as not potentially eligible, the person/legally responsible person should be notified in writing of the decision and given the option to obtain a recommendation from a physician. The person/legally responsible person is also given the option to obtain additional evaluations that may be of further support of the person's eligibility for the ICF-MR level of care. If the physician recommends, via completion of the MR-2 form, that the person meets ICF-MR level of care, the Lead Agency reconsiders the potential eligibility for CAP-MR/DD funding. The Lead Agency requests technical assistance from DMH/DD/SAS as part of that reconsideration. Should the Lead Agency continue to believe that the person is not potentially eligible for CAP-MR/DD funding, then the Lead Agency submits the MR-2 to EDS for eligibility determination. The Lead Agency mails the request to

EDS with a cover letter explaining the request. If the person is determined to be eligible for CAP-MR/DD funding, the Lead Agency notifies DMH/DD/SAS.

### 25.4 Appealing Level of Care Decisions—EDS Determination

EDS may determine that an individual does not meet the ICF-MR Level of Care when a MR-2 and supporting documentation are submitted for review by a Lead Agency Case Manager. If the person is denied by EDS, a Lead Agency or the person's physician may submit additional information to EDS on behalf of the individual supporting the level of care that was recommended by the physician. If EDS does not change its decision after reviewing the additional information, EDS sends a formal denial via certified mail. The denial contains specific instructions for the individual to follow if he/she wants to request an appeal. If an appeal is desired, there is an enclosed Appeal Request Form, which must be submitted to the DMA Hearing Officer by a specific date, which will be listed. Following the timely receipt of the appeal request, an Informal Reconsideration Hearing is scheduled. The Informal Hearing can be by telephone or in person at the DMA in Raleigh. The person and/or his/her legally responsible person may attend the hearing. The person/legally responsible person may have the Case Manager and other professionals who work with the person attend the hearing. The Hearing Officer, an outside Psychological Consultant, and a representative from DMA presents the findings. The person/legally responsible person can ask questions or present any information that may help the person's case. After the Informal Reconsideration Hearing, the DMA Hearing Officer and an outside Psychological Consultant review the person's records and the oral information obtained while listening to the oral presentations to determine if the EDS recommendation should be upheld to deny ICF-MR level of care. A letter is then sent to the individual/legally responsible person from the DMA Hearing Officer informing them of the decision to deny either deny or approve the ICF-MR level of care.

In the event that this decision is not satisfactory, the individual/legally responsible person may appeal to the Office of Administrative Hearings (OAH) within 60 days of receipt of the decision letter. If the appeal is not made within 60 calendar days of the receipt of this letter, the above decision cannot be appealed further. A petition for the formal (contested case) appeal is sent with the letter. The person/legally responsible person is also informed in this letter that in an appeal to OAH the person may represent his/herself or use legal counsel.

Section 9 contains information about criteria for the ICF-MR level of care.

### 25.5 Appealing Level of Care Decisions—Continuing Eligibility

The Lead Agency may also question a person's continued eligibility for ICF-MR level of care while the person is receiving CAP-MR/DD funding, particularly at the time of the person's Continued Need Review. Should this happen the Case Manager informs the person in writing that the question of eligibility is being referred to EDS for eligibility determination. A current MR-2 with a physician's recommendation for the person's level of care is submitted with current evaluation information, including information about the person's adaptive behavior functioning. The MR-2 is submitted with a letter explaining that the person already

has a prior approval number in the EDS system so that the person will not be issued a second number should EDS determine that the person continues to meet the ICF-MR level of care. EDS reviews the MR-2 and supporting documentation, and makes a decision about the person's continued eligibility for CAP-MR/DD funding. If the person is determined to no longer meet the ICF-MR level of care, the appeals process in Section 25.4 is followed.

For individuals receiving CAP-MR/DD services at a certain level of care, those services or that level of care will continue to be funded by Medicaid through the above process or until the petition is withdrawn, provided Medicaid eligibility continues.

### 25.6 Appealing Physicians Recommendations

Recommendations by the person's physician are not appealable. These include:

- A physician's recommendation for the level or type of care. The physician's recommendation is not appealable to Medicaid.

- A physician's order for services. Medicaid only pays for the services as recommended by a physician. If the person's physician recommends termination or denial of a service, the physician's recommendation is not appealable.

  **Example:** An individual who is participating in CAP-MR/DD feels he/she would benefit from physical therapy and requests that this service becomes part of the Plan of Care. The person's physician states physical therapy is not recommended and refuses to order the service. If a physical therapist orders therapy and the physician disagrees, PT may not be billed to Medicaid

### 25.7 Appealing Prioritization Decisions

If a person or his/her legal representative desires to appeal a Lead Agency prioritization decision, the DMH/DD/SAS Appeals process is followed. See Appendix P for this Appeals process.

### 25.8 Appealing Provider Terminations

Terminations or denial of services to a CAP-MR/DD recipient by a Provider Agency other than the Lead Agency are not appealable. Providers of CAP-MR/DD services or other Medicaid services may refuse to serve a CAP-MR/DD client. The Provider Agency's decision not to serve a client cannot be appealed. The Lead Agency's denial or termination may be appealed. The Provider Agency must notify the person/legally responsible person in writing of the decision to terminate and must give the person two weeks notice from the date of receipt of the letter of termination before the effective date of the termination. A Provider Agency may be exempt from the two weeks notice requirement if a health or safety issue is the reason for the termination. The person's Case Manager notifies DMH/DD/SAS if the written notification/two-week notice requirements are not followed. A Provider Agency who consistently fails to follow the notification procedure will be reported to DMH/DD/SAS and/or DMA for investigation.

**Example:** The person's guardian has been verbally abusive to the Day Habilitation direct service employees who have worked with the person. The Provider Agency has worked with the Case Manager in trying to alleviate the problem, but the guardian continues to be abusive. The Provider Agency refuses to continue serving the person and provides the person/legally responsible person with a written notification two weeks prior to the termination of services.

**Example:** The person has a new medical condition. The MR PCS employee is not trained to provide the care the person needs, and the Provider Agency is not a licensed home care agency so they cannot meet the person's newly identified needs. The Provider Agency believes that it would be dangerous for an untrained employee to provide MR PCS for the person, and notifies the person/legally responsible person and Case Manager that the agency is immediately terminating services.

## 25.9 CAP-MR/DD Denials, Reductions, Suspensions, and Terminations

Denials, reductions, suspensions, and terminations of CAP-MR/DD participation result from issues involving cost-effectiveness or health, safety, and welfare. If an individual does not have CAP-MR/DD and requests a hearing, rule out level of care and Medicaid eligibility issues to make sure a DMH/DD/SAS hearing is appropriate.

A denial of CAP-MR/DD is the refusal to initiate CAP-MR/DD services to an individual who:

- Is approved for ICF-MR level of care;
- Is eligible for the appropriate category of Medicaid; and
- Has been assessed for CAP-MR/DD and found eligible.

**Note:** An individual who does not meet all of the criteria listed above does not have the right to appeal the denial of CAP-MR/DD services or receipt of a waiver funding.

A termination of CAP-MR/DD participation is discontinuing the authorization of all CAP-MR/DD services to an individual who:

- Continues to meet ICF-MR criteria;
- Continues to be eligible for Medicaid under CAP-MR/DD, and;
- Has been participating in CAP-MR/DD.

A reduction of CAP-MR/DD supports is the lowering of the amount or type of supports being provided to an individual who:

- Continues to be approved for CAP-MR/DD services;
- Continues to meet the monthly allowable expenditure.

Lead Agencies that make a decision to deny, reduce or terminate CAP-MR/DD services follow the DMH/DD/SAS Medicaid Appeals Process. This Process is located in Appendix P.

### 25.10 CAP-MR/DD Denials and Terminations by DMH/DD/SAS or Lead Agency Local Approval Office

This section is for the applicant/recipient who is dissatisfied with a decision made by DMH/DD/SAS or the Lead Agency Local Approval Office when services are terminated or denied by DMH/DD/SAS or the Lead Agency Local Approval Office. An appeal of a decision by DMH/DD/SAS or the Lead Agency is made by following the process in Appendix P of this Manual.